

A pilot study into improving sickness absence recording in National Health Service acute trusts

Prepared by **Plymouth NHS Trust** and
Sandwell & West Birmingham NHS Trust
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Managing attendance at work is recognized as being an increasing priority for all employers. Both short term and long term absences have a significant impact upon the efficiency and resources of any company and the management of such absences can have a significant effect on both the company and the individuals who are involved. Within large public sector organizations such as NHS Trusts, the recording and management of absence can be inefficient and result in poor absence data. Many Occupational Health departments who are willing to help employees who have health problems find that their task is made more difficult by the lack of available “real time” data which identifies the reasons and dates of any absence spells and whether these are work related. Within the NHS, Occupational Health Services frequently only become aware of employee related health concerns following a referral by the line manager. The referral is frequently outside the recommended periods of time stated within policies and can also be lacking in many important details. This study aimed to explore ways that more effective “real time” data could be collected in order to assist both managers and occupational health in their efforts to support employees back to work, and to reduce the amount of work related ill health.

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EXECUTIVE SUMMARY

Overview

In the year 2005, sickness absence rates in the NHS ranged between 2.5-6.0% with an average of 4.5%¹. For the two NHS Trusts participating in this pilot, combined sickness absence costs during 2004/5 were around £14 million.

The National Audit Office (NAO) reported that whilst there had been consistent reductions in absence levels the NHS had failed to meet public sector reduction targets². Most attendance data systems used within the NHS are not real time, but are based upon data returned manually to a central manpower office and therefore reports are frequently 6 weeks out of date. Typically, data captured within NHS Trusts usually does not include reasons for absences, nor whether the absences were work related. This presents difficulties for monitoring achievement against reduction targets set by the Health and Safety Executive³.

Introduction to Pilot

Our pilot combined 3 separate elements of absence management:

1. Telephone reporting by employees at the start of their sick spell.
2. Automatic prompting by email, and if required by 'phone, to line managers and to occupational health whenever defined trigger points were breached on an individual basis.
3. Real time summary reports, enabling managers and occupational health to review overall attendance data, and to take appropriate action at both individual and organisational levels.

1 Dept of Health, Sickness absence rates of NHS staff in 2005, - 25th May 2006. <http://www.ic.nhs.uk/pubs/sicknessabsencerates>

2 Safer Place to Work: Improving the management of health and safety risks to staff in NHS trusts – National Audit Office Report 2003. http://www.nao.gov.uk/publications/nao_reports/02-03/0203527.pdf

3 The effective management of occupational health and safety services in the NHS DH Publications policy and guidance (17/12/01). <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/HealthAndSafety/fs/en>

An added benefit of the pilot was the collection of data on work-relatedness of all absences. Finally, the software was able to produce comprehensive statistical reports, useful for identifying problem areas and trends.

Our hypothesis was that a more co-ordinated, timely and consistent approach to absence management could result in the earlier use of support and rehabilitation programmes for individuals, leading to a possible reduction in overall sickness absence levels.

The pilot was predominantly led by the Occupational Health departments in each Trust as their own experiences from their clinical practice, was that referrals to OH from line managers were frequently inconsistent, in relation to timing and subsequent management follow up. The departments were keen to facilitate early OH interventions in the form of signposting to appropriate treatment services and the introduction of early rehabilitation programmes back to work. They also wished to have early knowledge of any potentially work related absences so that these could be investigated before they became chronic in nature.

The company providing the call centre and software package had worked with many smaller organisations and had reported around a 30% reduction in sickness absence levels when it was used. However, this was the first time they had worked within a large public sector organisation and it rapidly became clear that the process was much more complex within a large NHS employer owing to the variable shift patterns and communication systems. The change management aspects of introducing this type of system should not be underestimated.

Within the West Midlands a study undertaken by the Institute of Occupational Health in 2002⁴, highlighted that many Trusts were recording absence levels in different ways that could have a significant impact upon comparison of absence rates. For a staff member with a 1 day a week contract, a day off sick might be recorded as 1 day by some trusts, whilst some count the absence as being until the day the individual returns to work - a seven fold variation in this case. Trusts also have different approaches for non-sick absences, such as maternity or authorised leave.

Method

The process was managed by management personnel, occupational health and human resource representatives from two NHS Trusts, Sandwell & West Birmingham Hospital NHS Trust and Plymouth Hospitals NHS Trust. A tender

⁴ Sickness Absence in Nine NHS Trusts in the West Midlands, Johnson CJ, 2002 (Institute Occupational Health, Birmingham) Unpublished.

process was led by one of the Trusts and a software and call centre provider was selected from one of three interested parties. (The software selected was called *Absencia*).

The call centre and the associated sickness absence software were programmed in accordance with each Trusts' sickness absence policy. Once trigger points had been reached, the software automatically sent an email to the line manager prompting them to follow the actions suggested within their Trust's policy. Any absence perceived by the employee as being work-related also resulted in the system sending an immediate advisory email to occupational health. In one of the Trusts managers also requested telephone notification of any new absence, in addition to the email notification.

Each NHS Trust nominated a "division", and management and Union support was obtained for the pilot. Employees within the pilot divisions taking sick absence during the trial period were required to telephone the call centre instead of their line manager. The call centre asked a series of scripted but conversational questions and recorded details of the absence, as well as advising on arrangements for support services provided by the Trust, e.g. Employee Assistance Programmes, occupational health, physiotherapy, counselling, etc.

The line manager was required to email the call centre immediately upon the employee's return to work, to close the absence. The software queried long absences, in case the manager had inadvertently over looked the requirement to close the spell.

Periodically and automatically the software generated summary reports for line managers, human resources and occupational health. These were pre-defined, and contained information considered helpful for monitoring and review of absences at divisional, ward or an individual level.

Both trusts nominated medical divisions for the pilot. Within these, the population at Sandwell was 850 nursing staff, and at Plymouth 350 employees from all disciplines.

FINDINGS

The system recorded data for each of the 2 trusts, however for the purpose of the pilot, combined data is mainly presented. The pilot ran for 6 months, during which the number of absence spells recorded was 1816. This equated to an absence level of 4.5%, representing 200,085 lost working shifts.

14 simple categories for absence types were used and the top 5 self-reported absence types were (1) stomach and abdominal, (2) infections, colds and flu, (3) headache and migraine, (4) back and neck, and (5) musculoskeletal. Stomach and abdominal absences were the most frequent causes, although these were of short duration (mean 2 days). Stress and mental health absences were recorded less frequently, but resulted in the longest duration (mean 25 days).

During the study period, 6.6% (80) staff reported a self-assessed work-related absence, accounting for 7.5% (670) lost shifts. 47 (59%) of work related incidents were cited as being due to back / musculo-skeletal causes, 25 (31%) for infections (cold, "flu", diarrhoea and vomiting and 8 (10%) due to stress/mental health. On average, a work-related absence attributed to back / musculo-skeletal lasted 10 shifts, whilst one for stress lasted 30 shifts.

At Plymouth 9 (50%) of all self-reported work related absences were due to stomach complaints whereas at Sandwell this reason was only reported on 4 (3%) of cases. Subsequent investigation failed to find supporting evidence of any workplace outbreak at Plymouth during the pilot.

Table 1 - Work relatedness - Combined information

Incidences	Shifts Lost		As % of all
80	675		7.45%
Cause	Incidences	Shifts Lost	As % of all work related
Back	47	376	56%
Stress	8	242	36%
Other	25	57	8%

All organisations should report to the HSE any work related accidents that result in absences of greater than 3 days. Within the pilot period there were 23 (29%) reported work related absences meeting this criteria. As the system is real time system, rapid intervention was possible: Within Sandwell all employees reporting an absence due to perceived work related stress were contacted by the occupational health physician to clarify the reasons and offer further support. Individuals contacted were generally grateful, although it is not possible to say that this resulted in a shorter period of absence.

With only 80 reported work related cases (47 of which were backs and musculoskeletal problems, 8 were stress and 25 were others), it is impossible to draw conclusions of any statistical significance except to reinforce the view that the major two are the key causes of days lost for workplace related problems.

Table 1: Gives information on longer term absences (defined as those lasting more than 7 or 28 days) and data on spells within those groups which were work related

	Absences greater than 7 days						Absences greater than 28 days					
	Number	Days Lost*	WR No.	Days lost	% of abs	% by days	Number	Days Lost*	WR No.	Days lost	% of abs	% by days
Trust												
SWBH	174	4888	17	501	9.77	10.25	43	1759	6	303	13.95	17.23
Plymouth	55	1103	2	40	3.64	3.63	11	728	0	0	0.00	0.00
Combined	229	5991	19	541	8.30	9.03	54	2487	6	303	11.11	12.18

- Days lost includes absences which commenced prior to pilot but days lost figure includes only the days lost during the pilot period itself for these absences

Whilst the system easily identified differences between the two Trusts, and within the Trusts between wards and staff grades, larger numbers and a longer trial would be required before statistically-valid comparisons could be made. The database of absences following surgery has the potential to provide predictive absence durations after common procedures, which could assist managers in better planning of planned surgical absences.

Within Sandwell NHS Trust the average sick absence rate as recorded by the call centre over the 6 month project was 4.45%, whilst the hospital manpower system during this time for the same population group gave an all un-planned reasons absence rate of 7.1%. In this sense the call centre process could be described as reducing absence levels because it was recording true sickness absence rates. When the absence rates via the manpower system alone were compared before, during and after the study for the pilot division there was much less of a reduction in the average absence levels and it was not possible to undertake any statistical analysis of the data. It is therefore unclear whether the call centre system actually reduced absence rates during the short study period or just provided more accurate recording of the absences. What is in no doubt however is that the system readily highlighted attendance management failings whenever sickness absence trigger points had been breached, and it also rapidly highlighted individual cases that could be supported with much earlier occupational health related interventions.

LEARNING POINTS

It is important to remember that this was a pilot study aimed at assessing the benefits and problems that may arise from the introduction of a different absence management process. It had been recognised prior to the pilot that the sickness absence data would be too small and complex to make any meaningful statistical conclusions, however the pilot clearly demonstrated that the system could collect and present the data that was essential for effective attendance management.

It was evident from the pilot that the NHS presented a particularly difficult challenge for the introduction of a call centre approach to managing absence because of the need to cope with:

- A culture where acceptance of the management of attendance role by line managers was not universal and the implications and scope of responsibilities were not always fully understood – this represents a structural and organisational challenge for the NHS rather than the call centre.
- A culture where the identification of the causes of absence is not universally accepted – the call centre process met this challenge extremely well as shown by the data.
- The impact of rostering and the challenge of coping with complex patterns and types of shifts of varying duration. The call centre process met this challenge extremely well although there was a need to ensure more consistency of the data provided.
- A tie-in to the payroll system – this was not really tested as both Trusts maintained existing parallel paper recording processes to ensure that the pilot did not impact on pay.
- The challenge of managing attendance rather than simply sickness absence – this is not universally accepted and any system should record all forms of absence rather than simply that which is sickness related; i.e. both planned (holiday / maternity / training etc) and unplanned (sickness / domestic crisis etc) absence.
- The size and complexity of some NHS Acute Trusts and the 24 / 7 operation.

FUTURE PROPOSALS AND RECOMMENDATIONS

A satisfaction survey of staff and managers gave qualified endorsement of the system, although a number of learning points were identified that would enhance the system and may help to direct future research and study within the context of using a call centre approach to assist attendance management.

Recommendation 1

As managers appeared to find difficulty in “closing” absence spells, it would be advisable that whenever the sickness absence software is accessed by managers it gives immediate notification and prompts of all staff absences so that these can be updated.

Recommendation 2

Trusts should use an absence recording system that includes both planned and unplanned absences. This would avoid confusion of data recording using two different systems.

Recommendation 3

For best value to be gained from the real time and quality of information being generated, a dedicated individual should be identified to follow up the breaches in attendance targets as identified by the programme.

Recommendation 4

That it should be recognised that the value of an absence recording / call centre process is in its stimulus for better management of absence rather than in immediate cash savings.

Recommendation 5

That consideration is given to undertaking a full trial of this type of attendance management approach that should seek to:

- Prove any linkage to reducing Locum / agency costs
- Embed the OH processes described in this report into daily routines, in particular in respect of work relatedness
- Improve the linkage to Health & Safety within both Trusts
- Act early to assess any difference it makes
- Better quantify effects of improved information
- Indicate whether better prediction of absence duration really is an aid to planning
- Demonstrate improved attendance without the influence of the confounding variables present during the pilot

CONCLUSION

Any new absence management process that is introduced into a company is only likely to be as effective as the way it is used by the line manager. Effective line management action should therefore never be under-estimated when trying to evaluate the absence management process however this process is most certainly made easier for all concerned with reliable data that is “real time”.

The pilot successfully demonstrated a process that enabled absence reasons, durations and work relatedness to be recorded. The system provided managers with clear, timely and relevant data, affording them the opportunity to manage sickness absence in a more effective manner. It also provided occupational health with information relating to work related absences enabling early and appropriate intervention. Whilst it is not possible to state from this short pilot that the use of a call centre actually reduces sickness absence levels, there are pointers that it has the potential to do so – but establishing also whether it is a cost effective system requires further work.

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References have been arranged in the order in which they are referred to in the report.

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